

The Commonwealth of Massachusetts
Division of Health Professions Licensure
239 Causeway Street, 2nd floor, Suite 200
Boston, MA 02114
Board of Registration in Dentistry
(617)973-0971
www.mass.gov/dph/boards

INSTRUCTIONS FOR LIMITED LICENSE APPLICATION

A Limited License allows you to perform all the duties of a dentist but only in a hospital, school, or government clinic. **Practice in a private office is not permitted. Limited Licenses may be renewed yearly for up to five years.** To ensure that your application is accepted please provide the following:

- ☐ **Licensing Fee** - Check or money order is acceptable and made payable to the Commonwealth of Massachusetts for \$60. Cash is not accepted. All fees are non-refundable.
- ☐ **Supervising Dentist** - Any and all supervising dentists must be listed on the application
- ☐ **Passport Size Photo** - A photo (passport size) should be attached to your initial application.
- ☐ **Letters of Standing** - Certified letters of Standing must be included in the application from each state(s)/jurisdiction(s) in which you hold or held a license. These letters must include the current status of the license, license number and any disciplinary action taken or is pending.
- ☐ **Official Notification of Graduation** - Provide an official transcript or letter from your school of graduation. **Photocopies not accepted**
- ☐ **National Practitioner Data Bank Self-Query (NPDB)** - To obtain self-query please contact NPDB at 1-800-767-6732 or at www.npdb-hipdb.com. An original report from NPDB is required for application.
- ☐ **Practice History** - If you have been in dental practice in another jurisdiction or state, include a resume or practice history, including employer's contact information and dates of employment.
- ☐ **Exam** - The ethics and jurisprudence exam is an open book test designed to ensure knowledge of the Laws and Regulations of the state. The exam itself can be obtained by calling our office at (617) 973-0971 and one will be sent free of charge.

The exam is based on (1) Massachusetts' general laws pertaining to Dentists and Dental Hygienists and (2) Board of Registration in Dentistry Regulations 234 CMR of the Commonwealth of Massachusetts. Both documents are necessary to take the exam and are available from the State House Bookstore (Room 116), Boston, MA 02133. For the documents, fees, and/or mailing instructions contact the bookstore at (617) 727-2834. The Dental Laws and Regulations may also be obtained from our website www.mass.gov/dph/boards then follow directions to Board site and links.

- ☐ **SOCIAL SECURITY NUMBER (MANDATORY)** Pursuant to M.G.L. chap. 62C § 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will ascertain whether you are in compliance with child support and the tax laws of the Commonwealth.

Information on Clinics in Massachusetts: To request a copy of the “Directory of Clinics” in Massachusetts please contact the Statehouse Bookstore, Room 116, Boston, MA 02133 (617) 727-2834.

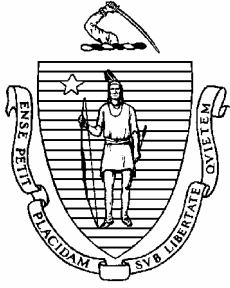
Once this application is processed we will issue a certificate with a license number. The license number and certificate will be sent to your **Supervising Dentist Only**. If you would like to know your license number, please call our office at (617) 973-0971.

To expedite the licensing process please send a complete application and all required documents to the Board:

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Incomplete applications will delay licensure processing.

**PLEASE BE SURE TO RETAIN A COPY OF ALL APPLICATION
SUBMISSIONS FOR YOUR RECORDS**



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BOARD USE ONLY	
Issue Date:	_____
License #:	_____
Fee :	_____
Juris Prudice:	Pass _____ Fail _____
Score:	_____
Exec. Dir.	_____

Please attach recent
passport size
Photograph here.

2 X 2

Signature required

Limited License Application

New ☐ Renewal ☐

Applicant Name: _____
(Last) (First) (Middle)

Maiden Name/Other Name: _____

Address of Record: _____
(No.) (Street) (Apt #) (State or Country) (Zip/Postal Code)

Most Recent Previous Address: _____

Date of Birth _____ Place of Birth: _____ Mother's Maiden Name: _____

Sex: Female ☐ Male ☐ Height _____ (Ft.) _____ (In) Weight: _____ Eye Color: _____

Telephone Number: Day: _____ Cell: _____

SOCIAL SECURITY NUMBER (MANDATORY) _____ - _____ - _____

Pursuant to MG.L. c. 62C, § 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the child support and tax laws of the Commonwealth.

List affiliations and addresses where you will be located:

Name of Institution/Clinic _____
Address _____
Phone# _____ Date of Employment: _____
Supervising Dentist _____ License# _____

Name of Institution/Clinic _____
Address _____
Phone# _____ Date of Employment: _____
Supervising Dentist _____ License# _____

Name of Institution/Clinic _____
Address _____
Phone# _____ Date of Employment: _____
Supervising Dentist _____ License# _____

Graduate of: _____
Year received diploma _____ Degree: _____

(A certified transcript of Original degree or Academic credentials evaluation must be attached)

Currently or planning enrollment in ADA accredited program: Yes ☐ No ☐ If yes, please provide name of school and expected year of graduation:

Have you ever failed a dental examination for any state or national or international jurisdiction i.e. state licensing exam, regional exam, or national exam? Yes ☐ No ☐ If yes please state details on a separate sheet.

List registrations in all other states or jurisdiction with issue date and current status:

<u>State</u>	<u>License Number</u>	<u>Issue Date</u>	<u>Current Status</u>

A certificate of standing from each state and jurisdiction in which you were licensed, indicating the status of your license and disciplinary information, must be submitted to the Board with this application.

Has a licensing board in another state or jurisdiction taken any disciplinary action against you? Yes ☐ No ☐
If yes, please state the details on a separate sheet.

Are you the subject of any pending disciplinary actions or complaints by a licensing board in another state or jurisdiction? Yes ☐ No ☐ If yes, please state the details on a separate sheet .

Have you ever voluntarily surrendered or resigned a professional license to a licensing board in another state or jurisdiction? Yes ☐ No ☐ If yes, please state the details on a separate sheet .

Have you ever applied for and been denied a professional license in another state or jurisdiction? Yes ☐ No ☐
If yes, please state the details on a separate sheet.

Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$100.00 was assessed? Yes ☐ No ☐
If yes, please state the details on a separate sheet.

I certify, under pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration in Dentistry to deny me a license or to suspend or revoke a license issued to me in accordance with Massachusetts Law. I further attest that, (a) pursuant to MGL, c. 62C, § 49A., to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law; and (b) pursuant to M.G.L. chap. 419 § 51A, I understand my obligation to report the abuse and neglect of children.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data (Agency Code: MABRNG). As an applicant for authorization to practice as a Dentist, I understand that a criminal record check may be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me.

Signature of Applicant

Date

TO BE COMPLETED ONLY IF RENEWING LICENSE

I certify that I have completed 20 hours of continuing education in the year preceding this application.

Signature

Print Name